



# Queen Anne's County Environmental Health

206 N. Commerce St, Centreville, MD 21617  
Phone: (410) 758-2281 Fax: (410) 758-6602

## APPLICATION FOR MOBILE RECIPROcity LICENSE

*Application is hereby made to operate a food service facility in accordance with the provisions of Health-General Article, §21-306, Annotate Code of Maryland; Code of Maryland Regulations (COMAR) 10.15.03; and all applicable State and Local laws and regulations.*

### The following documentation must be provided with this application:

- Copy of Food Service Facility license issued from "County of Origin"\*
- Commissary (Base of Operations) Agreement/Authorization and License
- Copy of Menu and Approved HACCP plan
- Photos of Mobile Unit (Interior & Exterior)
- Workman's Compensation Insurance Form & Emergency Contact Form
- Annual License Fee (\$250 = High Priority/ \$200 = Moderate Priority/ \$100 = Low Priority)

**\*Note:** "County of Origin" Food Service License is required for a Mobile Unit to qualify for a Mobile Reciprocity License.

Business/Trade Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Facility Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Owner's Name: \_\_\_\_\_ Owner's Phone: \_\_\_\_\_

Owner's Home Address: \_\_\_\_\_

Address Where Unit Will Operate: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

Vehicle License Plate #: \_\_\_\_\_ Vin #: \_\_\_\_\_

Water Supply: Public/Municipal  Private Well

Note: A private water supply (well) must be tested and approved per COMAR 10.15.03.18A.

Holding Tank Waste Water Disposal Location: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_ Position/Title: \_\_\_\_\_

ANNUAL FEE: \_\_\_\_\_ Annual fees must accompany each application. Make checks payable to: *Queen Anne's County Department of Health.*

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### OFFICE USE ONLY:

Date Fee Received: \_\_\_\_\_

QA license # \_\_\_\_\_

Amount Received: \_\_\_\_\_

date permit issued: \_\_\_\_\_



## Queen Anne's County Department of Health Environmental Health

### Food Service Fees

**Effective October 1<sup>st</sup>, 2008, the fee schedule is as follows:**

1. Temporary Permit Fee	- \$15.00
2. Low priority, annual	- \$100.00
3. Moderate priority, annual	- \$200.00
4. High priority	- \$250.00
5. Non-profit organizations	- \$ 0.00
6. Plan review fee	- \$ 0.00
7. Remodel and re-inspection fees	- \$ 0.00

**\* An explanation of the fee categories:**

1. \$15 Temporary Permit: includes any food vendor operating from a fixed location for a temporary period of 14 consecutive days or less. Example QA Co. fair vendors.
2. \$100 Low Priority, annual: includes those that serve/sell food rarely implicated in food-borne outbreaks; serve/sell coffee or other non-potentially hazardous drinks and pre-packaged snacks or pastries; serve/prepare non-potentially hazardous foods. Examples: Dollar General, Family Dollar, Rite Aid
3. \$200 Moderate priority, annual: includes those that serve/sell food occasionally at risk for causing a food-borne outbreak; that prepare foods within 4 hours of service; that do not cool and reheat foods. Examples: grocery stores, most fast-food chain facilities.
4. \$250 High priority facility: includes those preparing/serving/selling food to high-risk populations; preparing food more than a day in advance; that cook-cool-reheat foods; that prepare foods which are frequently implicated in food-borne outbreaks; any priority facility that has had an outbreak within the past 5 years. Examples; schools, nursing homes, full-serve restaurants, some fast-food.
5. \$0 – NO FEE –
  - a. Those facilities also licensed as wholesaler by the State Division of Food Control.
  - b. Bona fide non-profit organizations (church, fire hall, legions, etc.)
  - c. Plan reviews for new or remodeled facilities
  - d. Assisted living facilities of less than 17 residents.

State of Maryland  
Department of Health and Mental Hygiene  
Larry Hogan, Governor                      Dennis R. Schrader, Secretary

Office of Food Protection and Consumer Health Services  
Alan L. Taylor, Director

**Statement of Compliance with Worker's Compensation Act**

Maryland Health-General Code Annotated Section 1-202 requires that before any license or permit may be issued under the Health-General Article, the employer must file a certificate of compliance listing a worker's compensation insurance policy or binder number. Every employer who has employees anywhere in the United States, any United States Territory or United States possession, even if there are no employees in Maryland, must provide this information. This statement of compliance is based on the worker's compensation law applicable in the state in which the licensee is based.

**1. I have workers' compensation insurance:**

Insurance company name: \_\_\_\_\_  
Policy or Binder number: \_\_\_\_\_

**2. A waiver has been received from the Worker's Compensation Commission.** (Attach copy of waiver)

**3. As provided, I am exempt from having worker's compensation insurance.**  
(Attach copy of Certificate of Compliance)

**4. I am self-insured.** Approval of self-insurance has been received from Worker's Compensation Commission.  
(Attach a copy of the Certification of Compliance)

**5. I am self-employed. I have no employees.**

Circle the number of the option above which applies to you, provide the requested information, sign and date the form below and return it with the application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Company name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Company Address

Food Service Permit  
\_\_\_\_\_  
Type of License

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**FOR OFFICE USE ONLY**

New permit/license \_\_\_\_      Approved \_\_\_\_      Denied \_\_\_\_      Hold \_\_\_\_

Reason \_\_\_\_\_

By \_\_\_\_\_      Date: \_\_\_\_\_

## Emergency Contact Information

Please complete the information below. Return the completed form along with your food service application to Queen Anne's County Department of Health, Environmental Health.

<b>Facility Name:</b> _____	<b>Facility Phone #:</b> _____
<b>Tag number of Mobile Trailer or Mobile Truck:</b> _____	
<b>Facility Fax #:</b> _____	<b>Facility Email:</b> _____
<b>Owner's Name:</b> _____	<b>Owner's Email:</b> _____
<b>Physical Address:</b> _____	
<b>City:</b> _____	<b>State:</b> _____
	<b>Zip code:</b> _____
<b>Mailing Address:</b> _____	
<b>City:</b> _____	<b>State:</b> _____
	<b>Zip code:</b> _____

<b>Contact Person 1:</b> _____	<b>Title:</b> _____
<b>Phone #:</b> _____	<b>Cell #:</b> _____
<b>Contact Person 2:</b> _____	<b>Title:</b> _____
<b>Phone #:</b> _____	<b>Cell #:</b> _____

	Vendor/Supplier Name	Phone Number	Fax Number	Contact Person
1				
2				
3				
4				